

Reg. Dist. No. 2102



MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

BUREAU V. 2

SEP 28 1955

RECEIVED

8776

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Kent</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>37 Chester town</i>	LENGTH OF STAY (in this place) <i>2 mo</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>WORTON</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>72 Kent + Queen Anne's Hosp.</i>		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Rachel</i>	(Middle) <i>Wood</i>	(Last) <i>Carter</i>	OF DEATH: <i>9/19/1955</i>
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>	8. DATE OF BIRTH: <i>Dec 27, 1884</i>
9. AGE last birthday <i>70 yrs.</i>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>W. A. Wood</i>		14. MOTHER'S MAIDEN NAME: <i>Lillie Miller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>If No</i>		16. SOCIAL SECURITY No. <i>NONE</i>	
17. INFORMANT & ADDRESS: <i>Sara C. Burke Worton, Md</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE (A) <i>Cerebral vascular accident</i>		<i>9 months</i>	
ANTECEDENT CAUSE (B) <i>arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <i>hypertension</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March, 1955</i> , to <i>Sept</i> , 1955, that I last saw the deceased alive on <i>Sept 19</i> , 1955, and that death occurred at <i>3:45 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Florence Deranger Jace</i>		ADDRESS <i>Worton</i>	
DATE SIGNED <i>9/19/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 22, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Shell Pond. Cemetery</i>		LOCATION (City, town, or county) (State) <i>Shell Pond, Kent Co., Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Sept. 21-1955</i>		REGISTRAR'S SIGNATURE <i>Clara S. Barnes.</i>	
FUNERAL DIRECTOR <i>Marvin V. Williams - Chestertown, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8780

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08783

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 20

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Kent</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Kennedysville</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Kennedysville - Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <i>William Thomas Caulk</i>		4. DATE OF DEATH <i>Sept 2 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, <del>SEPARATED</del> , (Specify):	8. DATE OF BIRTH: <i>June 9, 1932</i>
9. AGE last birthday: <i>23</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Laboring</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farm</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>George Caulk</i>		14. MOTHER'S MAIDEN NAME: <i>Olivia Teller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <i>Olivia Caulk (mother) Kennedysville, Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Fractured skull with deep penetrating &amp; avulsing force</i>			<i>None</i>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>Highway</i>	
21c. (City or town) (County) (State) <i>Kennedysville, Kent, Md.</i>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>9 2 55 30 A.M.</i>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Struck by hit &amp; run vehicle</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>R. W. Fan</i>		M. D. DATE SIGNED <i>9/2/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>		DATE THEREOF <i>SEPT. 4 '55</i>	
NAME OF CEMETERY OR CREMATORY <i>MT. ZION CEMETERY</i>		LOCATION (City, town, or county) (State) <i>STILL POND, MD.</i>	
DATE REC'D BY LOCAL REG. <i>9/2/55</i>		24. FUNERAL DIRECTOR <i>B. R. FELLOWS</i> ADDRESS <i>STILL POND, MD.</i>	

BUREAU V. S.

SEP 18 1955

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SEP 18 1955



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## CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Sassafraz</u>		1		STREET ADDRESS		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				All rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Elgie E. Christy</u>				OF DEATH: <u>Sept. 26</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>May 28, 1880</u>	9. AGE last birthday: <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farming</u>				10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Sassafraz, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Leander Christy</u>				14. MOTHER'S MAIDEN NAME: <u>Augusta Kilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. MEDICAL CERTIFICATION			
9				22-09-1856			
17. INFORMANT & ADDRESS: <u>Effie Groomes, Sassafraz, Md.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
332X IMMEDIATE CAUSE				18 years			
(A) <u>Generalized Arteriosclerosis</u>							
ANTECEDENT CAUSE (S)				5 years			
(B) <u>Cerebral arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Scurvy</u>							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION: <u>no operation</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.) <u>Home</u>			
21C. WHERE DID (City or town) (County) (State)				21F. HOW DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>None</u> M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>3/2/55</u> to <u>9/26</u> , 19 <u>55</u> that I last saw the deceased alive on <u>9/22/55</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hamilton</u>				DATE SIGNED <u>9/26/55</u>			
ADDRESS <u>Millington Md</u>							
M. D. <u>Millington Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Sept. 30, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>John Wesley Church Cemetery</u>				LOCATION (City, town, or county) (State) <u>Sassafraz, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Sept 27</u>				24. FUNERAL DIRECTOR <u>Peppin Funeral Home</u>			
REGISTRAR'S SIGNATURE <u>E. E. Hamilton</u>				ADDRESS <u>257 E Main St</u>			
				<u>W. G. 2nd</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. 2

SEP 29 1955

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MARYLAND

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

8777

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37</u> <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> (rural) <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72</u> <u>Keyford Juven Arms</u>		STREET ADDRESS (If rural, give location) <u>Piney Neck</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Edward</u> (Middle) <u></u> (Last) <u>COLEMAN</u>		4. DATE OF DEATH (Month) <u>September</u> (Day) <u>18</u> (Year) <u>1955</u>	
6. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 19 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water man</u>		9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Maryland</u>	
13. FATHER'S NAME <u>William R. Coleman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Jane Benton</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Hospital Records</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause		(a) <u>Myocarditis &amp; Auricular fibrillation</u>	<u>Several years</u>
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>9-16-55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Incarcerated scrotal hernia, right.</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9-14, 1955, to 9-18, 1955, that I last saw the deceased alive on 9-18, 1955, and that death occurred at 4:00 a.m., from the causes and on the date stated above.

SIGNATURE ac'sick (Degree or title) M.D. ADDRESS Chestertown, Md. DATE SIGNED 9-18-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Sept. 20 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Am.</u>	LOCATION (City, town, or county) <u>Rock Hall, Maryland</u>	(State) <u></u>
DATE REC'D BY LOCAL REG. <u>Sept. 20 1955</u>	REGISTRAR'S SIGNATURE <u>Class J. Barnes</u>	24. FUNERAL DIRECTOR <u>Marvin V. Williams - Chestertown Md.</u>		

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 22 1963

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 2122

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>KENT.</u>		MARYLAND		STATE <u>Del.</u>		COUNTY <u>KENT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>CHESTERTOWN</u>		<u>4 HOURS</u>		TOWN <u>BLANCA</u>		<u>46X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>KENTY QUEEN ANNE'S HOSP.</u>				STREET ADDRESS (If rural give location) <u>Rt. #1</u>			
3. NAME OF DECEASED: (First) <u>OSCAR</u>		(Middle)		(Last) <u>DENBY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept 17 1955</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>May 5, 1901</u>	
9. AGE last birthday: <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm-hand</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Richard Denby</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>UNK</u>				16. SOCIAL SECURITY NO. <u>321-10-2841</u>		17. INFORMANT & ADDRESS: <u>Sister Mattie Denby Walker</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Concussion, Skull</u>						<u>4 hrs.</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Fracture,</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>INTERNAL FRACTURES, BOTH LEGS.</u>							
19A. DATE OF OPERATION: <u>19. 17. 55.</u>		19B. MAJOR FINDINGS OF OPERATION: <u>INTERNAL BLEEDING - Small intestine.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>HIGHWAY</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>Queen Anne's Md.</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Sept 17 55 1 P.M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>Automobile Accident</u>			
22. I hereby certify that I attended the deceased from <u>9. 17. 1955</u> , to <u>9. 17. 1955</u> ; that I last saw the deceased alive on <u>9. 17. 1955</u> and that death occurred at <u>7 P M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur J. L. Barnes</u>		ADDRESS <u>CHESBERTOWN Md</u>		DATE SIGNED <u>9. 17. 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>9-22-54</u>		NAME OF CEMETERY, OR CREMATORY <u>Blanco Cemetery</u>		LOCATION (City, town, or county) (State) <u>Blanco Dela.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 19-55</u>		REGISTRAR'S SIGNATURE <u>Arthur J. L. Barnes</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 11, Film G189 11-21-55 et

1. PLACE OF DEATH- COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>PENNSYLVANIA</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ROCK HALL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>READING</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FERRY PARK</u>		STREET ADDRESS (If rural, give location) <u>75X-3</u>	
3. NAME OF DECEASED (First) <u>PAUL</u> (Middle) <u>Y.</u> (Last) <u>FISHER</u>	4. DATE OF DEATH (Month) <u>SEPT</u> (Day) <u>2</u> (Year) <u>1955</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>52</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Phila. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>✓</u>	
13. FATHER'S NAME <u>Charles Fisher</u>		14. MOTHER'S MAIDEN NAME <u>7</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Homer Lange Reading Hill Pa.</u>			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a)..... <u>CORONARY THROMBOSIS</u>			<u>Immediate</u>
Antecedent cause(s) (b)..... <u>UNKNOWN</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from ..... 19..... to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at about 11:30 p.m., from the causes and on the date stated above.			
SIGNATURE <u>Willard F. Smith MD</u> (Degree or title)		ADDRESS <u>Rock Hall, Md.</u> DATE SIGNED <u>9/3/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>9-6-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Goodness</u>		LOCATION (City, town, or county) (State) <u>Reading Hill Pa.</u>	
DATE REC'D BY LOCAL REG. <u>9/5/55</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Church Hill</u>	

MARGIN RESERVED FOR BINDING





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH COUNTY <b>KENT</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WORTON</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>—</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>KENT</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WORTON</b> STREET ADDRESS (If rural, give location) <b>BUTLERTOWN</b>	
3. NAME OF DECEASED (Type or Print) <b>CLEMENTS</b>		4. DATE OF DEATH <b>SEPT. 4 1953</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. <del>SINGLE</del> MARRIED <del>WIDOWER</del> <b>MARRIED</b> (Specify)	8. DATE OF BIRTH <b>JUNE 15, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	9. AGE last birthday <b>66</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK HICKS</b>		14. MOTHER'S MAIDEN NAME <b>MYRA BERGEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY No. <b>218-20-7082</b>	
17. INFORMANT AND ADDRESS <b>LEWIS BLACKSTON WORTON R.F.D., MD.</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4-4-4 Immediate cause (a) <b>Pulmonary Edema</b>			
Antecedent cause(s) (b) <b>Hypertension</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Paralysis - Left side</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July</b> , 1953, to <b>Sept. 4</b> , 1953, that I last saw the deceased alive on <b>Sept. 3</b> , 1953, and that death occurred at <b>130 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE: <b>D. Kester</b>		ADDRESS: <b>Rock Hall 9/6/53 Md</b>	
23. BURIAL CREMATION <b>BURIAL</b> (Specify)		DATE THEREOF <b>SEPT. 7, 1953</b>	
NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		LOCATION (City, town, or county) <b>WORTON, MD.</b>	
DATE REC'D BY LOCAL REG. <b>9/6/53</b>		24. FUNERAL DIRECTOR <b>B. R. FELLOWS</b>	
REGISTRAR'S SIGNATURE <b>E. Kennard Jones</b>		ADDRESS <b>STILL POND, MD.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 8 1955

RECEIVED

8779

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Kent</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Baltimore City</i>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>37 Chestertown</i>	LENGTH OF STAY (in this place) <i>6 mo.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>3701-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>172 Kent Queen Anne's</i>		STREET ADDRESS (If rural give location) <i>✓</i>	
3. NAME OF DECEASED: (First) <i>Elizabeth</i> (Middle) <i>Torp</i> (Last) <i>mollen</i>		4. DATE (Month) <i>Sept.</i> (Day) <i>13.</i> (Year) <i>1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>Oct 2, 1881</i>
9. AGE last birthday: <i>73</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Home work</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Baltimore md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Un known</i>		14. MOTHER'S MAIDEN NAME: <i>Un known</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>9</i>		16. SOCIAL SECURITY No. <i>No.</i>	
17. INFORMANT & ADDRESS: <i>Angusta Jomer</i>		<i>Daughter</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>			<i>24 hours</i>
ANTECEDENT CAUSE (B) <i>Arteriosclerosis</i>			<i>years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Diabetes</i>			<i>years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sept. 6, 1955</i> to <i>Sept. 13, 1955</i> that I last saw the deceased alive on <i>Sept. 13, 1955</i> , and that death occurred at <i>1:30</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Willard Smith</i>		DATE SIGNED <i>Sept 15, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug 16-1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		LOCATION (City, town, or county) (State) <i>Baltimore md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Sept. 15-1955</i>		REGISTRAR'S SIGNATURE <i>Clara S. Barnes</i>	
FUNERAL DIRECTOR <i>Edgar L. Lane</i>		ADDRESS <i>Church Hill md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 19 1955

RECEIVED